STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155386	A. BUILDING 01 B. WING	05/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS OF DEKALB	520 W LIBERTY ST BUTLER, IN46721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/25/11 Facility Number: 000574 Provider Number: 155386 AIM Number: 100266430 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Laurels of Dekalb was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The orginal building consisting of the 100, 200 and 400 halls was surveyed with Chapter 19, Existing Health Care Occupancies and This one story facility was	K0000	The Laurels of DeKalb wishes to have this submitted plan of correction stand as our written allegation of compliance.Preparation and/or execution of this plan does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our date of compliance is 6/24/2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in in the corridors and areas open to the corridors. The facility has a capacity of 101 and had a census of 91 at the time of this survey. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/01/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0025 SS=D	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers was maintained to provide a one half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice was not in a resident care area but could affect any number of laundry staff. Findings include: Based on an observation with the Administrator and the Maintenance Director on 05/25/11 at 1:50 p.m., there was a one half inch hole in the ceiling beside the sprinkler head above the dryers in the laundry room. This was acknowledged by the Maintenance Assistant at the time	K0025	On 6/6/11 the Maintenance Director completed repair work to the ceiling smoke barrier in the laundry room. The penetration was repaired with thinset and fire caulk.The facility's Maintenance Director will ensure each room in the facility contains no smoke barrier penetrations as stated in the regulation.Continued compliance of the regulation regarding smoke barrier penetrations will be monitored by the Director of Maintenance through the preventative maintenance and fire safety programs. Variances will be corrected at the time of observation and trends will be reports to the facility's monthly Safety Committee and Quality Assurance Committees. The Administrator will monitor compliance with this regulation.	06/24/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	of observation. 3.1-19(b)			
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. Based on observation and record review, the facility failed to ensure 1 of 1 emergency lights was tested annually for at least a 1 1/2 hour duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency light for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observation with the	K0046	On 6/6/11 the Maintenance Director completed a test on the facility's battery operated emergency light located at the generator which lasted for 1 1/2 hours. The test was successful and the light worked without fault.The facility contains no other battery operated emergency lights.Continued compliance of the regulation will be monitored by the Maintenance Director through the facility's preventive maintenance program. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committees.The Administrator is responsible for the compliance of the regulation.	06/24/2011

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	Administrator on 05/25/11 at 1:30 p.m., a battery operated emergency light was observed at the generator. During record review with the Administrator at 12:30 p.m., a written record of an annual test regarding the battery operated emergency light was not available for review. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include:	K0050	On 6/3/11 the facility held a 1st shift fire drill at an unannounced time.No other fire drills were missing from the date of the last Life Safety Inspection.The facility's Maintenance Director will ensure each required fire drill is completed on each shift at varying times each quarter.Continued compliance of the timeliness of required fire drills will be monitored by the Director of Maintenance.	06/24/2011

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	Based on review of the "Monthly Fire Drill Report" with the Administrator and Maintenance Director on 05/25/11 at 12:01 p.m., there was no record of a first shift fire drill for the third quarter of 2010. Based on an interview with the Administrator and Maintenance Director at the time of record review, no other documentation was available for review to verify this drill was conducted. 3.1-19(b) 3.1-51(c)		Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committees.The Administrator will monitor compliance with this regulation.	
K0056 SS=E	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler heads	K0056	By 6/24/11 J.O. Mory, Inc. will move the sprinkler head in the 400 hall medication room and the sprinkler head in the laundry	06/24/2011

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	installed in the 400 hall medication room and 1 of 1 sprinkler heads in the laundry buffer room were at least four inches from the wall. NFPA 13, 5-6.3.3 requires upright and pendant sprinkler heads shall be installed at least four inches from the wall. This deficient practice was not in a resident care area but could affect and number of staff in the 400 hall medication room and the laundry room. Findings include: Based on observations with the Administrator and the Maintenance Director on 05/25/11 from 12:55 p.m. to 1;52 p.m., the sprinkler head in the 400 hall medication room was located three inches from the wall and the sprinkler head in the laundry buffer room was located two inches from the wall. This was acknowledged by the Maintenance Director at the times of observation. 3.1-19(b)		buffer room at least 4 inches away from the wall. No other sprinkler heads were found to be in violation of the regulation.Continued compliance of the regulation will be monitored by the Maintenance Director. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committee.The Administrator is repsponsible for compliance with this regulation.	

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K0067 SS=E	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on observation and interview, the facility failed to ensure 5 of 6 egress corridors were not being used as a portion of the return air plenum for heating, ventilating and air conditioning ductwork (HVAC) serving adjoining areas. NFPA 90A, the Standard for the Installation of Air Conditioning and Ventilation Systems at 2-3.11.1 requires egress corridors shall not be used as a portion of a supply, return, or exhaust air system serving adjoining areas. This deficient practice affects all residents, staff and visitors in the 100, 200 and 400 hall. Findings include: Based on observations on 05/25/11 during the facility tour with the Administrator and Maintenance Director from 12:50 p.m. to 2:30 p.m., all resident	K0067	The facility respectfully requests a waiver of K067. The Life Safety Waiver Request will be received by the State by 6/14/11.	06/24/2011

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	rooms on the 100, 200 and 400 halls were using the egress corridor as a return air system. Based on an interview at the time of observation, the Maintenance Director confirmed the return air was exhausted into the corridor for all resident rooms. The facility has modified the HVAC system so activation of the fire alarm shuts off supply air fans. Additionally, duct work connected to the supply air fans was equipped with duct detectors located downstream of the air filters. When activated, the duct detectors shut off supply air fans. Finally, since the HVAC ducts penetrated the smoke barrier walls, smoke dampers which close upon activation of the fire alarm system have been installed at the smoke barrier walls. 3.1-19(b)			
K0069 SS=E	Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 Based on record review and interview, the facility failed to ensure the complete range hood fire extinguishing system was UL	K0069	By 6/24/11 Fire Protection, Inc. will complete repairs on the facility's kitchen range hood fire extinguishing equipment to ensure it is UL 300 approved.No other facility equipment was	06/24/2011

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	300 approved. Life Safety Code (LSC) 19.3.2.6 refers to LSC 9.2.3. LSC 9.2.3 refers to NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96, 8-2.1 requires all actuation components, including remote manual pull stations, mechanical or electrical devices, detectors, actuators, and fire-actuated dampers shall be checked for proper operation during the inspection in accordance with the manufacturer's listed procedures. NFPA 96, 7-2.2 requires automatic fire-extinguishing systems shall comply with standard UL 300, Fire Testing of Fire Extinguishing Systems for Protection of Restaurant Cooking Areas. This deficient practice could affect any resident in the main dining room in the event of an emergency. Findings include: Based on review with Administrator and the Maintenance Director on 05/25/11 at 12:13 p.m. of the Fire Protection, Inc. range hood fire extinguishing equipment		found to be out of compliance with this regulation.The facility's Maintenance Director will ensure all necessary facility equipment is UL 300 approved.Continued compliance of this regulation will be monitored by the Director of Maintenance. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committees.The Administrator will monitor compliance with this regulation.	

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	inspection report titled "Range Hood Systems Report", the range hood fire extinguishing equipment was not UL 300 approved. This was acknowledged by the Maintenance Director at the time of record review. 3.1-19(b)			
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/25/11 Facility Number: 000574 Provider Number: 155386 AIM Number: 100266430 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Laurels of Dekalb was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety	K0000	The Laurels of DeKalb wishes to have this submitted plan of correction stand as our written allegation of compliance.Preparation and/or execution of this plan does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements. Our date of compliance is 6/24/2011.	

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	from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2. The 2004 addition of the B Wing (300 hall) and the Therapy Gym was surveyed with Chapter 18, New Health Care Occupancies. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in in the corridors and areas open to the corridors. The facility has a capacity of 101 and had a census of 91 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0046 SS=C	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on observation and record review, the facility failed to ensure	K0046	On 6/6/11 the Maintenance Director completed a test on the facility's battery operated	06/24/2011

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	1 of 1 emergency lights was tested annually for at least a 1 1/2 hour duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency light for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observation with the Administrator on 05/25/11 at 1:30 p.m., a battery operated emergency light was observed at the generator. During record review with the Administrator at 12:30 p.m., a written record of an annual test regarding the battery operated emergency light was not available for review. 3.1-19(b)		emergency light located at the generator which lasted for 1 1/2 hours. The test was successful and the light worked without fault.The facility contains no other battery operated emergency lights.Continued compliance of the regulation will be monitored by the Maintenance Director through the facility's preventive maintenance program. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committees.The Administrator is responsible for the compliance of the regulation.	

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	Based on observation and record review, the facility failed to ensure 1 of 1 emergency lights was tested annually for at least a 1 1/2 hour duration in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires an annual test shall be conducted on every required battery powered emergency light for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants. Findings include: Based on observation with the Administrator on 05/25/11 at 1:30 p.m., a battery operated emergency light was observed at the generator. During record review with the Administrator at 12:30 p.m., a written record of an annual test regarding the battery operated emergency light was not available for review.	K0046	On 6/6/11 the Maintenance Director completed a test on the facility's battery operated emergency light located at the generator which lasted for 1 1/2 hours. The test was successful and the light worked without fault.The facility contains no other battery operated emergency lights.Continued compliance of the regulation will be monitored by the Maintenance Director through the facility's preventive maintenance program. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committees.The Administrator is responsible for the compliance of the regulation.	06/24/2011

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K0050 SS=F	3.1-19(b) Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include: Based on review of the "Monthly Fire Drill Report" with the Administrator and Maintenance Director on 05/25/11 at 12:01 p.m., there was no record of a first shift fire drill for the third quarter of 2010. Based on an interview with the Administrator and Maintenance Director at the time of record review, no other documentation was available for review to verify this drill was	K0050	On 6/3/11 the facility held a 1st shift fire drill at an unannounced time.No other fire drills were missing from the date of the last Life Safety Inspection.The facility's Maintenance Director will ensure each required fire drill is completed on each shift at varying times each quarter.Continued compliance of the timeliness of required fire drills will be monitored by the Director of Maintenance. Variances will be corrected at the time of observation and trends will be reported to the facility's monthly Safety Committee and Quality Assurance Committees.The Administrator will monitor compliance with this regulation.	06/24/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS OF DEKALB	520 W LIBERTY ST BUTLER, IN46721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conducted. 3.1-19(b) 3.1-51(c)			